

**Social Support for Homeless Mothers**

**National Center on Family Homelessness  
Health Care for the Homeless Clinicians' Network**

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## Executive Summary

This descriptive, qualitative study represents a collaborative effort between the National Center on Family Homelessness and the Health Care for the Homeless Clinicians' Network to explore the social support experiences and needs of homeless mothers. These women have been neglected in the social support literature. Their needs and experiences differ markedly from those of the middle class on whom most social support findings are based. Therefore, it is vital that we begin, through systematic research, to explore the elements of social support that are necessary for helping homeless mothers stabilize in permanent housing.

Data for this study were collected from 100 women at 10 Health Care for the Homeless sites around the country using focus groups and a survey questionnaire. The questionnaire provided descriptive information on demographics, stress experiences, social supports, and services received and desired by the women. Women in our focus groups gave us valuable information about the type of supports they need and how best to deliver them, including:

- Providing instrumental support to meet basic needs.
- Recognizing the varied supports and services that provide homeless mothers the access they need to valuable social capital. The acquisition of social capital will equalize their opportunities to attain resources that enhance housing stability.
- Understanding homeless mothers' distrust and fear of providers, and the life experiences that contribute to these feelings.
- Willingness by providers to work patiently, persistently, and non-judgmentally with mothers to help address these feelings.
- Adopting procedures and policies to increase mothers' willingness to use available resources.
- Ensuring that supports are interdependent, rather than separate and isolated.

It is clear that a "one-size-fits-all" package of supports will not address the needs of these women or their children. Their service plans should be individualized and build on family strengths. Enhancing instrumental supports is an essential first step in assisting homeless families in their transition from homelessness.

Based on a literature review, focus group discussions, and informal feedback from providers, all programs serving homeless families and children should provide a core group of support services central to stabilizing families and improving their well being. Critical services necessary for the overwhelming majority of mothers and children include:

- Housing assistance
- Income support
- Transportation
- Childcare
- Case management
- Health care
- Trauma-informed services with psychoeducational groups
- Children's services.

It is clear that service plans must be generated in partnership with mothers. Since the passage out of homelessness is not a static event, supports need to be attuned to evolving needs as these women journey through the shelter experience toward independence and residential stability.

## **Introduction**

The National Center on Family Homelessness (NCFH) and the Health Care for the Homeless Clinicians Network conducted a study exploring the social support needs of homeless mothers, most of whom are parenting children alone. The study was undertaken to fill a gap in our knowledge about the support needs of poor and homeless women and to provide some guidance to providers designing and offering services to these women. To respond effectively to homeless women's needs we must define the nature and combination of supports and services that will help families stabilize in permanent housing (Bassuk, 1995).

Research to date on social supports focuses almost exclusively on middle class Americans and the working poor (Dohrenwend & Dohrenwend, 1974; Belle, 1990). Research has only begun to identify how social support processes are altered by poverty (Bassuk, Mickelson, Bissell, & Perloff, 2002). For example, the critical role of kin, particularly siblings, and the role of conflict in social support processes among low-income women has recently been identified. There is also evidence that poor women rely to a greater degree than middle class women on formal systems for certain types of social support (Bassuk et al., 2002).

This monograph describes the stresses and support needs of homeless women through their own voices. This description is based on the words and expressed needs and desires of homeless mothers. One hundred homeless mothers from 10 Health Care for the Homeless (HCH) sites across the country participated in the study. Each participant completed a survey questionnaire and participated in a focus group about their social support network and needs. The purpose of this study was to help clinicians understand the contribution of supports that are critical to meet the challenges of poverty and to help families achieve and maintain permanent housing.

This monograph begins with a review of the social support literature, especially as it pertains to poor women. The second chapter of the report describes the study design and data collection methods, and the limitations of the study. The results are presented in three separate chapters. Chapter 3 discusses the questionnaire findings. Chapters 4 and 5 summarize the analysis of information from the focus groups. The statements of the women, combined with what we know about social support and social capital, form the basis for the final chapter on recommendations for best practices.

## Chapter One: Background

- Causes of Homelessness
- Stress
- Social Support
- Social Capital
- Summary

### **Causes of Homelessness**

Structural factors, both political and economic, are major causes of family homelessness in this country. These factors include the income gap between rich and poor, the severe national shortage of affordable housing, and inadequate government assistance programs (Bassuk, 1995). These structural factors have nothing to do with personal characteristics or disabilities of homeless people (Goodman, 1991). Many female-headed families are at imminent risk of homelessness because of structural factors that are beyond their control including institutional barriers to economic opportunity for those in lower classes; lack of jobs that pay wages that cover the household and childcare costs for single-earner families; and the lack of affordable housing.

Many poor families face significant barriers to achieving or maintaining stable housing. These barriers include financial, social, and emotional demands that seriously strain poor families' ability to maintain stable housing. Single mothers must assume multiple roles – breadwinner; provider of 24-hour childcare, educational and emotional support for their children; nurse and crisis manager for the family – with little help from their informal social networks that are also impoverished and struggling to make it (Bassuk, 1995). Poor families already living on the edge because of the structural barriers they face can be catapulted into homelessness by what otherwise might be considered a minor event such as a child's illness, loss of transportation to work, or a rent increase.

The loss of a stable home has devastating effects on both children and adults. When families lose their residences, they also lose connections with formal and informal support networks. These networks of family, friends, service providers, and others are usually located in the neighborhood where the families lived. Homelessness impairs social networks by making it very difficult for families to maintain crucial social ties. Social networks are instrumental in anchoring families' lives and they take time to form. Their disruption has practical and emotional consequences for all network members. Social networks are important to all of us as a source of identification, information, various types of support, and sense of community. Without residential stability, families do not have the opportunity to build essential and lasting social networks.

Instrumental social support – money, food, access to jobs, childcare – is critical to families who are homeless, or at risk of homelessness. Instrumental support helps stabilize women and their families as they try to find jobs that pay a livable wage, locate affordable apartments, or while they wait to acquire the financial benefits for which they have applied.

The growing rates of extreme poverty have made it more difficult for low-income families to find and benefit from the instrumental or emotional resources that their informal networks provided in the past. Much of these families' support network has also been decimated by the effects of poverty, violence, drugs, and housing shortages (Roschelle, 1997). Therefore, families trying to avoid homelessness quickly exhaust whatever instrumental support friends and family have to offer as they strive to stay housed (Goodman, 1991).

## **Stress**

Stress can generally be divided into two major categories: acute stress and chronic stress and strain. Acute stress results from a significant, abrupt life event, such as the death of a family member, the loss of a job, or a serious illness. For the middle class, at least, acute stressors are more likely to occur independently of one another. This allows time for individuals, families, and networks to recover from or adjust to the stress without having to juggle other stressful events at the same time. If acute stresses pile up, middle class families generally have the necessary resources to deal with them and have more power to control the outcome.

Unlike acute events that call for an intense but brief response in order to help people regain a sense of stability, chronic stresses and strains accumulate and pile up on each other. Chronic stress often results from a continuous onslaught of acute stressors or from ongoing circumstances of risk and uncertainty. Chronic strain is the result of unrelenting hassles related to the performance of everyday activities. Both chronic stress and chronic strain wear out individuals, families, and networks over time. Poverty, homelessness, chronic illness, ongoing domestic violence, and neighborhood violence are examples of chronic stressors that can also create chronic strain. No families are immune to acute stressors. However, for poor families this stress occurs in the context of high levels of persistent stress and strain and a relative lack of buffering resources.

Poverty increases the likelihood of experiencing multiple chronic stresses such as those associated with inadequate housing and resources, increased exposure to violence, restricted opportunities, poor health status, special needs of children, and disintegrating social networks and neighborhoods. The experience of multiple stressors at any given time is harmful to the mental health and social relationships of disadvantaged people in part because of their limited opportunities to control, influence, or alter the stressors (Mickelson & Kubzansky, in press). It is not surprising that stress has been found to have a more negative impact on low-income people and those who are “disadvantaged” than on middle class people (Kessler & Neighbors, 1986).

In addition, chronic stress has both direct and indirect negative impact on social networks. Chronic stress affects social networks directly through the network members’ experiences of chronic stress. Indirectly, it results in members being too stressed to provide social support to other network members (Bassuk, Weinreb, Buckner, Browne, Salomon, & Bassuk, 1996). Social networks can disintegrate under the weight of accumulated chronic stresses. When an entire informal social network experiences multiple and cumulative chronic stresses, there are few resources for the network to share and little opportunity to build lasting supportive ties. In this way, poverty chips away at women’s supports and connections to others. This erosion of social support enables the events of women’s lives to become catastrophes and leaves them with no means of mitigating the effect of acute stresses and chronic strains in their lives.

## **Social Support**

Social support is made up of numerous elements. Its three major dimensions are the quantity of support available, the network structure, and the functional aspects – who provides it, what type of support it is, and its perceived value. The quantity of support available to a mother and her family is related to how closely connected they are to a formal and informal support network, and how often they have substantive contact with other network members (Turner & Turner, 1999). The structure of a network is determined by both its size and the degree of reciprocity that members experience. The functional dimension of social support includes the sources of support – kin or non-kin, formal or informal resources; the type of support sought and provided – instrumental, informational, or emotional; and how positive the support-receiver perceives the support to be.

The key element in all conceptions of social support, based on the middle class experience, is social relationships (Cobb, 1976). Social relationships are seen as vital to enhancing a person's ability to access and use social support. The problem with the middle class definition of social support when applied to disadvantaged populations, such as homeless and extremely poor mothers, is that it minimizes the importance of instrumental support. If a woman's basic needs are not met, no amount of emotional support will improve her circumstances and those of her family. Providing instrumental support is often the key to establishing a true helping relationship with a woman and her family as it indicates a genuine understanding of her current circumstances.

Acute and chronic stresses call for the mobilization of various social supports in order to minimize the impact of stress on the individual and the family. This is where disadvantaged families differ from middle class families. Socially disadvantaged families usually do not experience the level of support they need because their networks are overstressed, and they lack resources of their own. Adequate social support mobilization and provision are more likely to occur in networks where stress is at a reasonable level, such as in families and communities not buffeted by multiple ongoing acute and chronic stresses (Brown & Harris, 1978).

While social support is generally thought of as positive, there are instances where it has a negative impact on well being. Likewise, the extent of contact one has with a support network can work both ways. Ideally, more contact is beneficial. However, if a network is stressed, more contact with that network may increase, rather than decrease, stress. In addition, if a support network is riddled with conflict and tension, normal positive support processes are disrupted and more contact may increase stress (Coyne & DeLongis, 1986; Rook, 1984).

Conflict in relationships overrides other beneficial aspects of support. In the case of extremely poor women, Bassuk et al., (2002) found that women who reported conflict with members of their support network had more adverse mental health outcomes than those who did not report significant intra-network conflict. Conflict was more predictive of negative mental health outcomes than the amount of either emotional or instrumental support a woman reported. A damaged support network, or one that is characterized by conflict, is unlikely to be a source of adequate positive support of any type. Similarly, a negative sense of well being impairs an individual's ability to connect with and make appropriate use of available social supports.

## **Social Capital**

The concept of social capital can broaden our understanding of social ties. It also offers some promise in explaining the dynamic properties of social networks and the resources they help people access. Such an understanding can assist practitioners in their efforts to help poor and homeless mothers make lasting and sustainable changes in their lives.

According to Fernandez-Kelly (1994) social capital is best understood "as a process that facilitates access to benefits, rather than as a concrete thing appropriated by individuals or networks" (p. 90). Social capital consists of two interacting elements: social relationships or networks that allow individuals to gain access to the resources possessed by their associates, and the amount and quality of the resources that network members, including the individual, possess (Fernandez-Kelly, 1994; Portes, 1998; Onyx & Bullen, 2000). Social capital is important as it is a means for acquiring human capital which consists of capabilities that support and enhance one's functioning in the world (Portes & Landolt, 1996).

Social networks that form the basis of social capital must be created through strategies that formalize group relations that are reliable and that provide access to genuine resources (Portes, 1998). Resources that formal group relations provide access to can take many forms. They may be material and financial resources; informational resources that help one navigate an



unfriendly formal support system; or personal resources such as positive attitude, willingness to share experiences, and ability to provide emotional support.

Providers can assist poor women in developing social capital in two ways. First, providers can guide women in developing social networks – formal and informal – that are stable, built on mutual trust and reciprocity, and consist of others with resources that can make a difference in their lives. Second, providers can guide poor women in how to develop their own constructive personal and interpersonal resources that have value and can be shared with the network.

### **Summary**

The structural causes of family homelessness require a policy response at both the national and local level that specifically addresses macro-level issues related to homelessness. Nevertheless, within the current policy context there are things that service providers can do to make a difference in the lives of homeless women. Practitioners working with homeless women and their families can benefit from an understanding of how stress and social support processes interact negatively to disrupt or disempower a social network. The individual and family fallout from homelessness is amenable to intervention aimed at providing adequate supports and at building social capital.

## Chapter Two: Social Supports

- Study Design
- Sample
- Procedures
- Data Analysis
- Study Limitations

**Table 1: Focus Group Locations Social Supports**

Sponsoring Organization	Location Participants	# of Participants
Albuquerque HCH	Albuquerque, NM	13
Northeast Valley Health Corp.	Los Angeles, CA	14
HCH of Milwaukee	Milwaukee, WI	11
Pueblo Comm. Health Center	Pueblo, CO	11
HCH, Comm. Health Dept.	Minneapolis, MN	10
Philadelphia Health Management	Philadelphia, PA	10
Barone Street Catholic Charities	New Orleans, LA	7
Springfield HHS Department	Springfield, MA	11
Vista Colina Emergency Shelter	Phoenix, AZ	10
Seattle-King County DPH	Seattle, WA	3
<b>Total # of Participants</b>		<b>100</b>

### Study Design

This study is a descriptive, qualitative investigation of the social support needs identified by a convenience sample of homeless mothers. It was designed collaboratively by the National Center on Family Homelessness (NCFH) and a task force of clinicians and administrators from the federally-funded Health Care for the Homeless (HCH) program. Data collection consisted of two parts: focus groups and a survey questionnaire. The instruments for both were developed collaboratively by NCFH, the HCH task force, and an outside expert in social support for poor women. Many of the questions were derived from instruments and interview protocols that had been previously used with populations of homeless and extremely poor women.

The 10 HCH sites that hosted the focus groups made up a convenience sample of programs located around the country in both urban and rural settings. An effort was made to choose sites that would ensure geographic diversity and a range of sizes and scope of services. The same group facilitator conducted all the focus groups. Topics discussed in the focus groups included the various sources of support – family, intimate relationships, friends, children, and formal supports - and services the women used. The survey questionnaire consisted of demographic information and questions about social supports, stresses, barriers to supports, and services the women received. A total of 100 homeless mothers completed the written questionnaire and participated in the 10 focus groups.

### Sample

The focus groups were held in ten cities across the United States that were geographically diverse (*See Table 1*).

Site representatives were asked to recruit 7–10 homeless mothers who represented the population served by the site, *and* who fulfilled the following study criteria:

- Age 18 or over;

- Spent the previous night in a mission, homeless shelter or transitional shelter, a hotel paid for by a voucher, a church or chapel, an all-night theater or other indoor public place, an abandoned building, a car or other vehicle, the street or other outdoor public place, or a rehabilitation facility for homeless people;
- Mother of dependent children 17 years of age or younger for whom she was the primary provider at the time of data collection;
- Sufficient cognition to be interviewed; and,
- Did not have disruptive bipolar or schizophrenic disorders.

The focus group facilitator relied on the judgment of the referring clinicians regarding the last two items. No formal or standardized screening instrument was used to determine if these criteria were met although the survey questions covered most of these issues.

Each participant received a \$20 incentive (provided in cash or voucher form according to site preference) for her participation in the study. Each site received a \$400 incentive for activities related to recruiting subjects and providing space for the focus group and the reception that followed. The focus groups were held at the health care facility or at emergency family shelters or transitional housing programs.

### **Procedures**

Each participating HCH site was asked to appoint a representative to be the “point person”. This meant that s/he would become a member of the Social Supports Project Task Force and would participate in conference calls about the project. S/he would also be expected to:

- Recruit clients for focus group participation;
- Set up space for focus groups at or near the site;
- Provide snack foods/drinks for participating clients;
- Arrange for child care and transportation for participating clients, as needed;
- Appoint a representative to be available during the data collection process;
- Purchase and distribute gift certificates for participants;
- Consult with research specialist via phone or e-mail; and
- Fulfill local IRB requirements.

Once a participant agreed to take part in the study, she was asked to sign a consent form. The focus group facilitator read the consent form aloud to the participant to ensure that she thoroughly understood all elements of the process before signing the form. Site representatives provided snack foods/drinks for participants following the focus group session and survey. During the reception the site representatives also “checked-in” with the clients to assess mental or emotional stress and to provide information and access to specific support staff and services available (both at that time and later).

### **Data Analysis**

The data collected from the surveys were tallied for reporting purposes. Means were calculated on certain variables (e.g., age, length of current homelessness, children’s ages, etc.) to summarize various client characteristics. In most cases percentages do not appear in the tables since they were identical, or very close to, the actual number of women (i.e., the sample size was 100 women).

Each focus group was taped and the tapes were transcribed and coded by the group facilitator for themes. Themes were aggregated across groups and qualified for inclusion in the study only if they arose in more than one of the groups and represented the responses of multiple persons within the group.

## **Study Limitations**

While the women interviewed for this study represent a diverse sample of homeless mothers from locations throughout the U.S., they were not randomly selected, and the sites where they were recruited were not randomly selected. Therefore, the results reported here cannot be generalized to the population of all homeless mothers. Since items in the questionnaire related to trauma experiences focused solely on interpersonal violence, it was not possible to determine the true extent of the women's lifetime trauma experiences. In addition, it is not possible to determine the quality, structure or function of the social supports that women identified on the questionnaire. Although the women reported they could approach family or friends for certain types of support, there is no way to determine the extent or quality of the support they actually received. The *perceived* quality and function of support is evident in the focus group material, but there was no attempt formally to measure actual *received* support. Nevertheless, the results are valuable for extending our understanding of the stress, social support, and best practices issues for these women and their service providers.

## Chapter Three: Findings from Questionnaire

- Demographics
- Current Benefits
- Children
- Violence/Victimization Experiences
- Social Supports
- Services
- Most Helpful Services Received
- Barriers
- Summary **Chapter Three**

### **Findings from Questionnaire**

The findings from the questionnaire portion of this study begin to tell the story of these women's lives. We see who they are demographically, what benefits they have been receiving, and who their children are. We learn about the stress in their lives related to violence and victimization, and the social supports they feel are available to them. They tell us about the services they have and have not received, and services they have found to be most helpful. Finally, we learn about the barriers they have faced in trying to survive and to provide some stability for themselves and their children.

### **Demographics**

The average age of the focus group participants was 31.7 years, which is similar to that in other studies of homeless mothers (Rog & Gutman, 1997). The average number of children living with each mother was 2.3. The majority of the women were African American (56%) with Hispanics (16%) and Whites (20%) accounting for another 36% of the women. The remaining 8% of the women were Asian, Native American, or other ethnicity. Twenty-seven percent of the women were living with a spouse or intimate partner, while the remaining 73% were not living with a partner because they were separated, divorced, widowed, or never married. The median family income for the previous year was \$3600—well below the poverty level for a three-person household. (mean income was \$6,507/year). (*See Table 2*).

While the number of women who had at least a high school education and the number who had not finished high school was virtually the same (47 vs. 48), a total of 61 women had either graduated high school or completed their GED. The majority of the women (78) were unemployed at the time of data collection. Nineteen of these women were participating in a job training program. An additional 22 women were working full- or part-time.

Eighty-five of the women were currently homeless for an average of 10 months at the time of the study. An additional 13 had been living in a doubled-up situation for an average of 6 months. The mean number of times the women had been homeless as adults was 2.2 with an average total length of time homeless of 1.5 years. The women had moved 0 to 15 times in the past two years with an average of 3.2 times. Sixteen of the women had been in foster care as children.

**Table 2: Demographics**

Variable	Number
<b>Age (Mean)</b>	31.7
<b>Ethnicity/Race</b>	
African American	56
White	20
Hispanic	16
Asian	1
Native American	4
Other	3
<b>Relationship Status</b>	
Never married	49
Married	18
Living with intimate partner (not married)	9
Separated	13
Divorced	9
Widowed	2
<b>Children</b>	
Number of children living with you now (mean)	2.3
<b>Income</b>	
Total family income in last year (median)	\$3,600
Total family income in last year (mean)	\$6,570
<b>Education</b>	
Highest grade completed < High School	48
Highest grade completed ≥ High School	47
Graduated high school or received GED	61
<b>Employment and Training</b>	
Currently <i>not</i> working at a paid job	78
Currently in job-training program	19
Currently working full-time (32 hours +/-week)	13
Currently working part-time	9
<b>Housing Status</b>	
Doubled-Up	13
Currently homeless (not doubled-up)	85
Mean time currently homeless	10 months
Number of times homeless as an adult (Mean)	2.24
Length of time homeless as an adult (Mean)	1.5 years
<b>Foster Care—Ever in foster care as a child?</b>	16

### **Current Benefits**

The participants were receiving an array of benefits from various social programs (*see Table 3*). However, except for Food Stamps and Medicaid/Medicare, less than half of the women were receiving any other type of government benefits. Women reported that TANF benefits and WIC (Women, Infants, and Children Program) were the next most frequently received benefits. Less than one-fifth of the women reported receiving subsidies for housing and childcare, disability income support (SSI or SSDI) or emergency assistance.

**Table 3: Benefits**

<b>Benefit</b>	<b>Number</b>
Food Stamps	7
Medicaid/Medicare	61
TANF (Transitional Assistance for Needy Families)	44
WIC (Women, Infants, and Children Program)	36
Housing Subsidy (e.g. Section 8)	18
Child Care Subsidy	18
EA (Emergency Assistance)	17
SSI (Supplemental Security Income)	11
SSDI (Supplemental Security Disability Income)	6
Other	12

### **Children**

The women had a total of 227 children living with them at the time of the study (*see Table 4*). The average age of the children was 7.3 years, and they were equally divided between boys (n=114) and girls (n=113). Thirty-three percent of the children had not lived with their mothers for the majority of the last 30 days. Study participants reported that 12% of their children had serious medical problems, and 5% of the children had been in foster care at some point. (We did not gather data on the number of children that had been removed from their mother's custody.)

**Table 4: Children**

#### **CHARACTERISTICS OF CHILDREN (N=227)**

<b>Variable</b>	<b>Number</b>
<b>Age (Mean)</b>	7.3
<b>Gender</b>	
Boys	114
Girls	113
<b>Who Child has Lived with Most for the Last 30 Days</b>	
With you (respondent)	150
Father	9
Parents or siblings	13
Other relatives	4
Foster care	7
Other	27
Not reported	17
<b>Serious Medical Problems? (Yes)</b>	28
<b>Ever had a Child in Foster Care? (Yes)</b>	11

## Violence/Victimization Experiences

The study participants reported a significant level of physical and sexual abuse in the past year as well as in their childhoods (*see Table 5*). One quarter of the women reported being physically abused by someone in the past year. Eleven of the women reported being forced to have sexual relations against their will and nearly a third reported being emotionally abused by a partner in the past year. Nearly one fifth of the women reported being afraid of their partner and the same number reported being threatened by their partner. Over a quarter of the women reported restrictions imposed by their partners in their social activities.

Thirty-five of the women experienced physical abuse at some time during their childhood while 40 experienced sexual abuse. Both kinds of abuse lasted for long periods – 10.5 years for physical abuse and 5.8 years for sexual abuse. These levels of childhood trauma echo those of other studies of homeless mothers (Bassuk et al., 1996). The actual range of trauma these women experienced cannot be determined from the questionnaire responses since the questions focused solely on interpersonal experiences of violent victimization. Trauma associated with witnessing violence and with significant losses was not assessed.

**Table 5:**

**Violence/Victimization Experiences** \**This table indicates “Yes” responses to these items*

<b>Stressor</b>	<b>Number</b>
Afraid of current partner or anyone else	18
Partner or companion frequently belittles, insults, or blames you	29
Partner or companion has stopped you from going places or seeing people	27
Partner or companion threatened to harm you, your children, or your relatives	18
Has been kicked, pushed, shoved or otherwise hurt by someone in the last year	25
Has been forced to have sexual relations against your will in the last year	11
Experienced physical abuse as a child	35
Age at which physical abuse began	8.2 years
Duration of child physical abuse (Mean)	10.5 years
Experienced sexual abuse as a child	40
Age at which sexual abuse began	8 years
Duration of child sexual abuse (Mean)	5.8 years

## Social Supports

The women were asked for information about sources of emergency, financial and emotional support. Their responses appear in *Table 6*. Except for financial support, the women reported more support from friends than from any category of family members. Friends and family sources provided the bulk of the support the women perceived to be available. They were more likely to turn to parents than siblings or partners, and rarely perceived that clergy or professional providers would be sources of support. Nevertheless, 64 of the women agreed that they would be willing to seek help from friends or family, and 73 agreed that they would be willing to seek help from professional providers when stressed. Obviously, there is a wide gap between whom they would go to for help if they were stressed and who they perceive would actually be receptive to their request for help.



**Table 6: SOCIAL SUPPORT****SOCIAL SUPPORT-number of “yes” responses**

	Could Contact if Emergency in the Middle of the Night	Could Contact if Needed Money	Could Contact if Depressed and Needed Advice
Parents	39	23	28
Brothers or Sisters	33	18	23
Partner/Husband	15	6	15
Grandparents	10	5	8
Friends/Neighbors	46	16	33
Hotline/Community Crisis Line	16	5	14
Professional Provider	9	4	10
Clergy	6	4	7
Other	11	22	18
In general, willing to seek help from <i>close friends and relatives</i> when stressed (Yes)	64		
In general, willing to seek help from <i>professional providers</i> when stressed (Yes)	73		

**Services**

The majority of the women in the sample were receiving food assistance and medical care for themselves and their children (*see Table 7*). Slightly more than one-third were receiving assistance to obtain entitlements, and less than one-third were receiving assistance in finding housing and childcare. Nearly a quarter of the women reported assistance with education/job training, transportation, emergency cash, and money management. Services the women expressed the greatest interest in receiving, if they were not already receiving them, were: assistance in finding housing, transportation, job training/referrals, emergency cash, and money management. The services the women were least interested in receiving were: mental health services for themselves or their children; substance abuse services; support groups; preschool programs (the average age of the children was 7.3 years); legal assistance; and nutrition information.

**Table 7: Services Received or Desired****SERVICES CURRENTLY RECEIVING—Number of responses to each question**

Service	Currently Receiving Service			I want more information about this service
	YES	NO But I want to receive the service	NO I do not want to receive the service	
Food assistance	64	14	7	15
Medical care for you or your children	59	10	5	20
Dental Services	39	27	3	21
Assistance in receiving Entitlements (e.g., TANF, Medicaid, SSI, etc.)	37	11	17	14
Assistance in finding housing	29	35	4	35
Parenting information	28	19	22	16
Mental health services for you or your children	27	11	32	18
Childcare	27	23	16	19
Job training/referrals	23	30	13	24
Money management/budgeting	21	27	17	20
GED program/other education	21	18	25	15
Transportation	21	33	11	25
Nutrition information	19	19	27	12
Support groups/therapy for you or your children	19	23	28	22
Emergency Cash	17	32	8	27
Preschool/Early intervention for your children	17	14	32	14
Parental mediation/legal assistance	12	23	28	21
Substance abuse services for you or your children	7	11	46	9

**Most Helpful Services Received**

Housing and health care topped the list of the most helpful services the women had received or would like to receive in the near future (*see Table 8*). Means-tested programs such as TANF and Food Stamps had also been helpful in the past year, but as the women looked into the future they wanted assistance with things that would improve the quality of their lives and stabilize them in the community – housing, health care, job-related activities, child care, and transportation. The social safety net had been important to these women during difficult times, but they also indicated a desire to move toward self-support and recognized what they would need in order to accomplish that.

**Table 8: Most Helpful Services Received and Desired****Most Helpful Services Received and Desired***(Respondents indicated up to three)*

<b>Services most helpful to you and your children in the past year</b>	<b>Number</b>
Health care	32
Shelter	25
Housing	19
Benefits (SSI, TANF, Welfare)	15
Food (Food Stamps)	13
Child care	6
<b>Services that would be the most helpful to you and your children in the immediate future</b>	
Housing	45
Health care	18
Job related (training, search)	17
Child care	14
Transportation	11
Education	10

**Barriers**

As is evident from *Table 9*, more than half of the women identified housing, jobs, and lack of money as the most difficult problems they face in trying to live a satisfactory life. In addition, nearly half of the respondents named two additional barriers to self-support: living in a shelter and lack of transportation. All these barriers or problems require instrumental support to overcome.

**Table 9: Barriers Faced Most Difficult Problems in Trying to Make it in Life***(Respondents indicated up to three)*

	<b>Number</b>
Don't have good housing	54
Not having a good job	54
Not having enough money	51
Having to live in a shelter	46
No transportation	45
Not having an adequate education	26
Feeling down or depressed	25
Not getting a break from children	22
Being alone/no one to talk to or count on	17
Trouble with physical health	15
Being abused by male partner	11
Using alcohol or drugs	10
Trouble raising children	7

## **Summary**

In summary, the typical study participant was a 32 year old homeless mother of color with 2.3 children whom she was parenting alone. Her yearly income was well below the federal poverty level. Although she had a high school degree or equivalency, she was not working at a paid job at the time of the study. Over one-quarter of the children of these women had at least one serious physical health problem. A significant number of the women had experienced disruptions in their own childhood and twenty-five percent or more reported being subjected to emotional or physical abuse in the past year.

Friends and family were the primary sources of support mentioned by the women – with friends being the predominant source of emergency and emotional support and parents being the major source of financial support. However, the questionnaire did not explore the quality or true extent of those supports. It is important to remember that the family and friends of these women may be in similar circumstances and coping with similar stresses. If this is the case, the networks' capacity to provide significant support may be quite limited. Although they expressed a general willingness to seek support from both formal and informal sources if stressed, the women did not perceive that clergy or professional support was generally available to them.

In general, the services the women used most frequently and found the most helpful were services that met their instrumental needs – housing, health and dental care, money, transportation, and child care. Some were also receiving parenting classes and mental health services. The major barriers the women faced in achieving some quality of life were housing, jobs, money and transportation.

These findings suggest that instrumental support is critical to these women if they are to move toward stability and quality of life. Interventions are perceived as most helpful when they focus on providing housing and job-related services, and on meeting basic needs. A consumer-driven service plan provides the opportunity to develop trusting, productive relationships since it recognizes and addresses the most immediate needs of these women and their families.

## Chapter Four: Findings-Stress and Trauma

- Stresses Related to Housing
- Stresses Related to Employment
- Parenting Alone
- Mothering
- Domestic Violence Experiences
- Concerns about the Abuse Pattern
- Summary

Homeless mothers are quintessentially stressed women. Poverty is an extremely potent stressor in which the frequency, intensity, and duration of stressful events are heightened (Belle, 1983). Finding affordable housing, adequate-paying jobs, transportation resources, childcare, and health care are serious challenges. Within this context, a majority of homeless mothers are raising children alone. Complicating this picture is that poverty is also associated with high prevalence rates of violent victimization. A recent study of homeless mothers revealed that 92% experienced severe physical and/or sexual assault during their lifetimes, and that 88% had been subjected to violence at the hands of someone close to them – family members or intimate partners (Bassuk et al., 1996).

### **Stresses Related to Housing**

As the mothers reported in the questionnaires, their primary need is for decent, affordable housing, but housing was simply not available to homeless families in their communities.

*“If they turned half of the abandoned and boarded up houses in this town into shelters, we would be fine.”*

*“There should be some more low income housing that is based on 30% of the income that you receive. That would be real nice if everyone had that opportunity to have somewhere to live instead of on the street.”*

*“I find the biggest obstacle is finding affordable housing.....Finding affordable housing in decent neighborhoods.”*

While affordable housing is a huge obstacle to their exit from homelessness, these mothers clearly recognize the importance of housing stability to both them and their children.

*“If you give them a bath at the same time every night, if it’s quiet at the same time at night, they need that. So, that’s been a big problem for me. And that’s what I am looking forward to ... just getting my kids on some type of a schedule again.”*

*“I went from one transitional living to another. It is hard. It is hard because I am trying to set a foundation for my kids. I am trying to have some stability in my life because I am tired of going from one shelter to another shelter. I see the changes in my children also.”*

*“When you live out of a shelter, your child goes through so much instability. She don’t want to sleep by herself now. Before we had those problems she was in her own room loving it by herself. Now I have to be under her 24/7 because she is scared.”*

## **Stresses Related to Employment**

### ***Inadequate Pay***

Without question, the primary barrier to employment is finding jobs that provide a livable wage. A livable wage is one that allows the women to save enough to get ahead financially, to make it possible to pay for quality childcare, and to provide for their family's basic needs. The majority of the study participants who were working had jobs that paid about minimum wage.

*"That's probably why a lot of people are homeless, too, because the jobs that they have to take they never make enough money."*

*"I have a job, but I am making pennies, you know what I mean?"*

*"There's no way you can get ahead." "When you get on welfare and you get a job, GAIN ain't going to get you no job making no \$12, \$13, \$14 an hour which is what you need really to make it a little bit. You know, no \$6 an hour job going to help you. You might as well stay on the county. ...after taxes every two weeks making \$200-\$300 that's how much you going to get from the county anyway."*

*"We need EDD with employment so we can get a decent job or help us to go to school for something else besides a CNA or a Medical Assistant. I got both of those certificates, thank you. They don't let you get nowhere. As far as you are going to get is \$5, \$6, \$7 an hour. And what that's going to do is keep you right back down. You're gonna get depressed, get disgusted, and start using again."*

### ***Transportation***

An additional stress is the lack of adequate and reliable transportation options for getting to work, to child care settings, and to schools in time to pick up children. Public transportation systems fall short of meeting the needs of these mothers. One mother described why public transportation was not working for her family:

*"My husband has his own business and he works to clean windows, and you naturally can't clean a window at night. So, if I choose to work at night so we don't need day care, then it's hard, you know, because the buses only run up until a certain time. It's hard to get a job when you already have restrictions. Okay, well, I can't come to work until 6:00 and I have to be off by 9:45 because of the last bus runs, you know? ...They want to go with somebody that says I will work 45 hours a week and you don't even have to pay me overtime. There's people that are like that so it's really hard."*

### ***Parenting Alone***

Parenting alone is a stress for these mothers. Focus group participants discussed several types of stressors related to caring for their children. These include finding decent, affordable, trustworthy childcare so that they can work. Another is their concern about parenting effectively and overcoming negative parenting role models.

### ***Childcare Availability***

Many of the women struggled to find decent, affordable childcare so that they could work or go to school.

*“...it’s not that the childcare is not out there, the childcare is available, it’s a matter of being able to afford it. And even though the state has childcare assistance programs, the waiting list is so long that you could be homeless before you ever get that assistance.”*

*“The day care that they give homeless people is like homeless daycare. It’s like so low budget, you know what I mean?”*

Referring to eligibility for a childcare subsidy program:

*“Like me, they limit the amount of money you probably are able to make. ... as soon as I get a job, I’m not going to be eligible because of the money that I’ll be making.”*

*“That’s how I ended up homeless. It wasn’t that I couldn’t find jobs, it is that I couldn’t afford childcare and pay my rent. It was a choice between me going to work and paying for childcare or me not working. And childcare was \$70 a week. I was in the service industry and this is the time of year it is slow so I got cut back on the job and I just couldn’t do it. I couldn’t drop \$700 a month on rent and childcare and \$150 a month for utilities. I just didn’t have it.”*

Another said time slots were her problem:

*“They have third shift but if you don’t have your own vehicle to get you back and forth where you need to go, you would really have a problem with time slots. You can’t drop them off early enough to get to work on time.”* (Three of the mothers in this particular group had lost jobs or had to take fewer work hours as a result of scheduling problems with day care.)

### ***Trusting Childcare Providers***

Like all mothers, homeless mothers want to be able to trust the childcare providers they hire. Since their trust in people has been violated repeatedly by their experiences of childhood and adulthood physical and sexual abuse, many of the mothers have difficulty trusting people in general and day care providers in particular. This lack of trust plays a tangible role in hindering access to childcare. The following are some typical comments:

*“I never trusted anybody with my kids.”*

*“You don’t know those people, you know?”*

*“Day care just scares me.”*

*“I have a hard time trusting because I am always suspicious.”*

*“I am very picky. I went to three different places (for day care) before I was happy. I would not go to a house. I didn’t want a house day care because of everything that is going on. I didn’t want that.”*

*“...There are very few people that I trust with my child. It is just a very sensitive subject for me.”*

*“...a huge fear factor, because I don’t want to leave him because I am so afraid of my ex-husband [and] the crap that he pulled. ... I just don’t leave him. I’m too paranoid. It’s awful.”*

Accessing childcare that could handle their child(ren)’s special needs was an additional frustration for some of the mothers. For example, mothers in two locations could not find care for their children who had severe behavioral disorders. A mom in another location could not find care for her child who experienced seizures. One mother had two children with disabilities; this would have cost \$200-300/week for proper daycare. Instead she had her older children babysitting them, which she feared was too great a burden on them.

### **Mothering**

One thing these mothers hold on to is the importance of themselves as mothers. “Mother” is a core identity for them and they take the responsibility of parenting seriously (Friedman, 2000; Fernandez-Kelly, 1994). They often get messages from society that they have “messed up” or “failed” and are undeserving and dysfunctional. They worry that they will be seen as “unfit” because they are homeless.

### **Challenges**

While the desire to be a good role model and to see their children have a better life is often a source of motivation, caring for the children and ensuring their well being is a challenging responsibility due to their extreme poverty.

*“I don’t want my kids to sleep another night in the car, you know. You have to pull yourself up by your bootstraps.”*

One mother who had been relocated to a new city to avoid her abuser remarked,

*“Just getting up and not knowing where you are going is hard enough, and then with a four year old, it’s harder. So, I get up, get dressed, do my thing and you know try to find my way around here so I can learn.”*

*“It’s really wearing and tearing on my body because now I am getting headaches from stress and I don’t sleep that much and my appetite is not the same. But, I mean it just keeps me going because like you know for my kids. Because if I don’t do it then who’s gonna take care of my kids?”*

*“Sometimes the cycle (of welfare) can be hard to break. If they see you out there working to do it yourself, it makes your kids have character also.”*

*“I am upset with myself because my kids shouldn’t have to go through it.”*

*“I don’t want my past to be my child’s future. You know, it may be too late for my 18 year old, she’s out of my home now, but it’s not too late for my 11 year old. And it’s not too late, I am only 40 and it’s not too late for me to have a good life.”*

*“I just look at them and I can’t let them [her children] down, you know. Letting them down just makes me feel so bad.”*

*“When your kids are safe and happy it helps you to stay happier.” “My child is the reason I get up in the morning and do what I gotta do.”*



## ***Children's Health***

Many of these women had children with chronic medical illnesses and were very frustrated trying to find affordable health care for them.

One woman said her son had asthma and needed medicine that cost her \$120/month, which she could not afford. Another's daughter had a "fungus on her head."

*"Medicaid wouldn't pay for it [the prescription]. It is \$160. I don't have that type of money to go to the pharmacy. I had to break down the payment..."*

*"...without that Medicaid card I would be broke. I thank God for Medicaid."*

Many were frustrated with HMOs, partly due to co-pays: *"If you miss an appointment they charge you \$10 for not going."* and, *"If you miss your appointment, you can be dead, they still charge you...it's \$20 a visit if you miss."*

Many women also spoke of frustrations accessing care for their children when they were most in need.

*"Every time I try to go to a public community health center in the last three months, they tell me to go to the emergency room. They don't have enough employees and they have too many clients."*

*"My son desperately needs dental care, he can't get it because he is too young. I have to wait until he is five years old, and he's got what's called chronic infantile tooth decay."*

*"No doctor would see him so I had to take him to the emergency room just because he had a minor cold. Just to get some medicine, just to get a prescription so I could get some medicine."*

*"We want to be good parents and we want to take care of our children for life's sake, and they are really interfering in our ability to effectively parent our children."*

They also commented on other implications their child(ren)'s poor health had on their lives:

*"I had one with a chronic lung disease who had just been diagnosed with cerebral palsy. I have another one with a chronic infection and she just lost her hearing in her right ear. Then I have a son with a heart condition and migraine headaches. So, when I did work I always got fired because I was a no show or I was missing too many days because I was tending to my children."*

*"I have lost jobs because of my son. He was born premature. He was born one pound and 12 ounces. And my son has a chronic lung disease too from being on ventilators so long. And I have a daughter that has asthma. ...It takes a toll on you when you are working. You get called, oh, you need to go to the hospital, you know?"*

*"...one of the reasons I home school my daughter is that she is handicapped. It's not a physical handicap, but she has a body tremor, which means her handwriting is not that legible. It doesn't look like 7th grade handwriting, it looks about like messy 3rd grade handwriting."*

## Domestic Violence Experiences

Nearly all of the study participants reported having experienced or witnessed abusive relationships at some point in their lives. The following stories give an indication of what some of these women have been through.

*“My dad gave me two black eyes and broke three of my ribs...when I was in kindergarten. That was a spanking to my dad. That wasn’t a baseball bat to your head, that was nice, that was getting a spanking.”*

*“I was nine weeks pregnant with her and he put a gun in my mouth and kept pulling the trigger but the gun jammed. So when the police got the gun and they cocked it, it went off. ...That was the first domestic relationship I have ever been in before*

*“I got cuts on my head because he used to bust my head with bottles and everything. That slowed me down.”*

*“When I was with my husband, who is now facing twenty-five to life for what he did to me and what he did to my daughter, I was forbidden from having any friendships even camaraderie with my own children, you know, for a year and a half. I wasn’t even allowed to speak to my children without words that were okayed by my husband first.”*

## Concerns about the Abuse Pattern

Many of these women expressed concern about being caught in a cycle of abuse, where each of their intimate partners turned out to be abusive. One woman had been involved with an abusive man, then got married to someone who also turned out to be physically abusive.

*“One time it might be a mistake, but twice you know there will be more times after that.”*

*“I grew up in a foster home that was abusive. I left home when I was 13 and I was abused. I’ve had abusive relationships with men. Since I have been in therapy I have learned that I am going to stay away from men until my radar is fixed.”*

*“As a child I was abused, you know, and molested, and so naturally when I got into adulthood, that’s what I looked for. And I wasn’t aware that that was what I was looking for. But when I was with somebody that actually treated me good, I didn’t know how to accept that...”* This woman also struggled with her own abusive behavior toward her husband.

## Summary

Motherhood is a core identity for these women, and yet their ability to provide the bare necessities for their children is severely limited. They are frustrated by the many roadblocks they encounter and worry that others will see them as “unfit” because they struggle to manage hurdles that are outside of their control. They face multiple stresses in multiple areas of their lives on a daily basis. The stresses are complex and exacerbated by lack of resources and lack of control over their circumstances. Although housing would provide crucial stability for them and their children, they find access to affordable housing limited. As the single earner in the family with

limited education, they face enormous barriers to obtaining jobs that pay a livable wage. Even if jobs were readily available, they would face the nightmare of negotiating inadequate public transportation systems and finding decent, reliable childcare, sometimes for a child with special needs. Many also have experienced the trauma of domestic violence and its aftermath. This not only adds to their experience of stress, but also impacts their ability and desire to form other relationships.

## Chapter Five: Findings-Social Support

- Self as Support
- Informal Supports
- Formal Supports
- Job Skills/Training
- Help for Domestic Violence Situations
- Parenting Supports
- Respite
- Self Help Groups
- Summary

Social support is a critical buffer for stressful events and a major predictor of emotional and physical well being. Supports not only ameliorate stress, but can also prevent crises from occurring. Many homeless women never had the robust supports that enable poor women to survive (Bassuk, 1995). This makes it difficult for them to access and trust available supports. The women in the focus groups talked about informal and formal sources of support.

### **Self as Support**

Overwhelmingly, these homeless mothers feel alone. They believe the only way they will transition out of their homeless situation is to find the strength within themselves.

*“What I learned is only me is going to help me. Nobody else.”*

*“I don’t have support. The only support system that I have is myself and my AA groups that I go to. I gotta look within myself...”* (Everyone in the group instantly agreed with this latter statement.)

*“If I don’t have it in me...I ain’t never gonna get out of this situation.”*

*“I was always told you don’t go ask for help, you do it on your own. You are responsible for your actions.”*

*“You don’t want to ask nobody for nothing. You just want to do it on your own at your own time and pace.”*

*“The bottom line is get off your butt and take care of your business. There ain’t nobody gonna do it for you, you got to help yourself to a piece of the pie.”*

This is not to say, however, that they all felt they had the self-esteem or energy to “make it” all by themselves.

*“Your self-esteem is going down because you can’t do it all yourself.”*

*“I find myself questioning me.”*

### **Informal Supports**

Informal social support networks typically consist of family, friends, and community supports. They are characterized by mutual aid and are based on interactions of choice (Roschelle, 1997). There is an implied reciprocity in informal social support networks-that one is both a giver and a receiver. Homeless mothers have more conflicted relationships with kin

than with friends or professionals (Bassuk et.al., 2002). These conflicts can impede the flow of support as conflict often overrides other positive experiences of support. In addition, if women do not perceive the networks as helpful or available, they are less likely to request help from network members.

### ***Family Conflict and Betrayal***

As was evident from the questionnaires, these women by and large do not rely on family or perceive them as a reliable source of support. For some, family members were not a reliable source of any kind of support; they shared experiences of feeling betrayed by their family.

*“You never really know who is by your side until you actually get into a very bad situation, you know what I am saying? And it’s like it just seems like everything is cool with your family and your friends until you need them...”*

*“You never know how a person is until you live with them. Family will screw you first and that’s the truth.”*

*“Family is the worst because that is why I ended up here. .. I wanted to know, how can you do that to me? I am your sister’s daughter, you know?”*

*“It is hard being in somebody’s house. My sister put me out when that big snow was going on in 1996. She put me out in the snow.”*

One woman moved in with her mother.

*“My mom even had us out, put us out in the rain. We were walking in the rain with my children. No place to go.”* She went on to explain the impact this has had on her children: *“They don’t understand the woman and my son don’t want nobody near me. They don’t trust nobody. They don’t want nobody in my face... She done locked me in rooms, all kinds of crazy stuff and my sons have seen this stuff you know what I’m saying.”*

*“A stranger will help you before your family.”*

*“I have family members that have helped me, and that’s when I felt the most homeless. I am happier homeless than I was at home.”*

### ***Absence of Families***

For others, family members are dead or otherwise absent from their lives.

*“I was the only child my mother had. My mother had lung cancer and she died a year and a half ago.”*

*“My mom had passed away first of all, that’s how I ended up homeless because I was living with her and my stepdad. ...He went to stay with his mother...”*

*“My mom died when I was 14 years old. I have no idea where my father is.” “I was abandoned at age 15. I stay to myself a lot.”* Her therapist was encouraging her to learn to trust again, but she was not sure she could: *“everybody I have opened to in trust they have took advantage of me.”*

### ***Stressed Networks***

Many of the participants recognized that their networks were stressed and, therefore, not available to them.

*“My mom, she just had brain surgery in November, so I can’t be there having all the problems that I have and going through things that I am going through. She can’t worry about me. She has to worry about her...”*

*“My mom had a very hard life. She had eight kids and she had to raise them all by herself. She had three jobs just to support all of us. You know, I never saw my mom. ...I didn’t have a dad.”*

*“My mom ain’t in no better predicament than I am. She can’t help me no more.”*

Others in this group pointed out that while her mom could not help her out financially, at least she had her support: *“Yeah, but you can talk, you know? Some of us have mothers but we can’t go and talk to them. Me, I ain’t got nobody. ...she may not be able to give you no money, but the thing is, she’s there. She’s alive.”*

### ***Reluctance to Depend on Family***

Others expressed reluctance to turn to family because of the failure such dependence implied, along with the self-esteem they would lose.

*“You can always go back, but there’s a part of being independent. ...Like in my case, my family likes to be a crutch. It’s easy to get sucked up in it.”*

One woman had a sister who she said would do anything for her, but spoke of their very different lives and her sister’s “perfect children.” *“I don’t want to impose my life style on my nephews...it would take away from her parenting.... I choose not to disrupt her.”*

*“My sister will let me live with her for a year, you know. And, they don’t want to see that. They say if you really, really, really, really need to stay with us you can, but we want to see you try and do something because you have kids and they look up to you guys, you know what I mean?”* She also mentioned that it would be demeaning for her husband, as well, to move into her sister’s garage.

### ***Friends as Support***

Despite their responses to the questionnaire indicating that they would turn to friends in an emergency and for emotional support, none of these women said they had a friend.

*“There ain’t no such thing.”*

In one group the women were asked why they hadn’t referred to friends as sources of help, and they said: *“That’s because we don’t have no friends.”*

Many of these women lost their “friends” when they gave up substance abuse.

*“I can call them up right now and tell them, hey, I need some money can you come down here and they’ll come down and get me, you know what I mean? But then I am back up in that circle again and I’m busted again and I have worked real hard...I put myself through a drug rehabilitation program.”*

*“Once that [money] ran out [to support their habits], they ran out. So I don’t have any friends. None.”*

*“If you want to go get high, we’ve got all kinds of friends everywhere.”*

*“You find out real quick how real your friends are.”* Conflict with Friends

### ***Conflicts with Friends***

Others shared experiences of conflict and betrayal with friends they had trusted, particularly female friends. Many of these comments refer specifically to experiences they had living with friends.

Referring to *female* friends: *“They have always been better than me or they are after my man.”*

*“I ain’t having no more female friends in my house.”* This woman said her closest *girlfriend* had put her out of her apartment. Another stayed with her close girlfriend for two months while she was looking for an apartment: *“She stopped coming to pick up my kids cause she got mad at me cause her boyfriend liked me.”*

One woman said her girlfriend started stealing from her and her family: *“We lost everything we had and so then we moved in with my mom. Do you know that that made me hate every female there is to hate.”*

When a *woman* in the New Mexico group said *“I don’t trust nobody”* everyone instantly agreed.

### ***Children as Supports***

Nearly all of the mothers considered their children a source of support as the children have been an important motivator for staying clean and sober and navigating the systems they need to in order to survive and transition out of their situations. In some cases, they were over-reliant on their children to bolster their own self-esteem, to serve as confidantes, and/or to take on family responsibilities such as babysitting the younger children.

This was certainly not the case for all of them – parenting classes seem to have made them aware of the implications of excessive reliance on their children. Unfortunately, these women reported few other appropriate, reliable sources of support.

*“My self-esteem lies with my children. They let me know every day that I am doing the best I can.”*

*“The oldest boy is quitting school to go work to bring some money to the family.”*

*“My oldest daughter, we call her the little mother...she would get up at 2:00 in the morning and feed them [brother and sister] and change them and do everything...”* This mom had been in a major depression at the time and was in the process of weaning her daughter of this level of responsibility.

*“The children want to be children and you don’t want to put this responsibility to a kid. ..If I was to sit down like I be talking to these ladies and let it all on my kids, my children are going to lose all consequences and sense.”*

One woman said she had learned the “hard way” the dangers of relying too heavily on her oldest child – she warned the others in the group: *“Do not put it on your children to have that friendship because your children are children and need to be children. They don’t need to be your companion.”*

### ***Spirituality***

In most of the groups, at least one participant commented that she found strength to endure her situation from a spiritual source. For these women, their spiritual beliefs are a great source of comfort and support.

One woman said her inner strength *“actually comes from [the fact] that my life has been turned over to the Lord and that is where I get the strength from.”*

*“Just when I thought my life was over, you know, like God gave me a second chance at life.”*

*“The only friend that I truly have is God. I don’t have friends.”*

*“I might not have a place to stay, but I am content. And as long as I keep walking my walk in Him, He’s blessing me with what I need, not what I want, but what I need.”*

Not all of the women found spirituality as a source of support. The following is a comment from a woman who envied those who found strength in “God” but could not seem to embrace it herself:

*“You know, they say, pray to God and I do believe in the prayer of God and I know things just don’t come like no doggone miracle and they take time. But sometime these streets and ending up having your child cold when you are sleeping in this car so nobody be looking at you—it makes you start thinking of a whole lot of different other things. I am not saying everybody. I’m just saying what it does to me. The prayer tends to be the least on my list. ...my first impulse is not God right then.”*

### **Formal Supports**

Formal supports consist of the service systems – entitlement programs, shelters, job-training programs, health care, etc. – and the individuals who work within those systems. A recent study found evidence that suggests that women in need of support from professionals were severely economically, socially, and emotionally depleted, and their situations were more desperate than those who did not report professional instrumental support (Bassuk et al., 2002). We can assume, then, that those who come to professionals for help are likely to be the most in need, the most depleted and the most stressed. In addition, race, gender, and class represent interacting categories of oppression that are prevalent within the service system as a whole. The women distinguished between “support” and “help” – a distinction that may reflect the difference between emotional and instrumental support.



*“Support is great, but help is going to get you where you need to go...and getting the help is the hard part. You can find support everywhere, good, good, good because you are going to need that support when you don’t get the help.”*

*“I think that people give more pity than they give us help. ...Don’t give me things, help me get it for myself. Don’t give me pity, give me a way to help myself. If you just give me everything I need to do it, then I am not going to know how to do it myself when I do have to get out there.”*

### **Service System**

The participants generally felt that the service system does not help mothers who are at imminent risk of becoming homeless. In fact, the women found resources to be much less available when they were struggling to avoid becoming homeless. Instead, they felt that the “system” was set up to help only when they became homeless.

*“You gotta hit rock bottom before somebody will help you.”*

One mother *remarked* how several types of assistance – e.g., with utilities or rent - are available on a time-limited basis. For example, *“If you having problems, you are low on rent or whatever, you can only get help for that one month and the next month you are stuck again...”*

*“Once you go mental, they will send for somebody. But they won’t prevent you from going mental.”*

*“I personally feel like if I had gotten assistance before now, then maybe I wouldn’t be homeless. Honestly, if they had helped me then [when she had a low-paying job] I probably wouldn’t be where I am now. But, now they want to give me all kinds of cash and all kinds of food stamps. ‘Oh, okay, now you are homeless and you live in a shelter, okay, now we’ll help you.’ And I am thinking why didn’t you help me before it came to this point?”*

*“You are falling and there is no net there to catch you.”*

*“They see you going there [bottom] and they want you to hit it before they help you.”*

*“There are so many things out there that are going on, but you have to be down at your very lowest point to even find out about them.”* Referring to asking for help: *“You are trying too hard to get back up in the top of that tree, you don’t want people to know that you are falling down ....You’re damned if you do, you’re damned if you don’t.”*

### **Service Providers**

Social workers, case managers, shelter providers, and other service and benefit providers were perceived as barriers to access to needed services, especially when they interacted with these mothers in ways that were humiliating, judgmental, critical, or punitive. While a few of the women relayed positive experiences with case managers, the vast majority discussed encounters with social service workers and other professionals that were not helpful. The vast majority of the women felt that the staff they encountered blamed them for their current situation. For many of these women dealing with bad or attitudes was at least as frustrating as inaccessibility.

Describing an *interaction* with a welfare worker: “*She was just being very rude and mean to me and I didn’t think I deserved that.*”

*“It seemed like they were frustrated because we had a lot of questions. I am new at this, you know what I am saying?”*

*“People aren’t in these positions because they just flat out want to be, you know, destitute and down. The customer service is terrible. People talk to you like you’re just the bottom of the barrel, trashy, don’t have nothing, probably never will have nothing, ‘you never are going to be as good as me’ type attitude. . . .It’s just messed up when people are in that for a paycheck instead of what the actual job description is really all about. You should have some passion for wanting to help somebody.”*

One mom walked out of her social worker’s office in disgust for the way she was treated: “*If you want to treat me like I’m a nobody when I ain’t got nothing, treat me like a nobody when I got something.*”

*“I think there should be people that constantly go around to all these agencies and come in and talk to people and make sure they are being treated right.”*

Part of what makes enduring the attitudes so frustrating is that the outcome does not always seem to be worth the hassle or wait:

*“They act like they are giving you so much money. That money does not cover even half of the things that we need.”*

*“Just because I am in a shelter that does not mean that I am less of a person. Just because I am on welfare that doesn’t mean that I can’t do the same thing that you are doing. I just need a little bit more help to get there.”*

*“It’s not their money. The government gave that money to, you know, help families, single moms, whatever. But you would think it was their money the way they treat you.”*

A lot of these women found agency personnel inaccessible:

*“I am tired of them having me run around like a chicken with my head cut off and all that stuff. I am sick of welfare.”*

*“When you call they have an answering machine and you can’t get through. There’s no getting through. You leave messages, they don’t return your calls.”*

Many found that, with persistence, they eventually encountered someone who treated them with respect. The following are some of the “strategies” they shared with each other.

*“People will treat you the way you treat yourself.”* Some will treat you without respect, she said, and *“People going to treat you that way.. That’s just something we just have to overcome and deal with.”*

*“We need help in a lot of areas, and we can’t get that help if we don’t speak up.” “If you go there and you talk really nice to them, they will help you. But if you go in there with some attitude they won’t help you. They don’t care.”*

The women repeatedly returned to the theme of staff performing selective-helping. The perception that staff treated clients differently was pervasive throughout the groups. It was clear, though not stated overtly, that racism played a role in some of these experiences.

*“They will pick Vickie and they will pick Emma Lou. And they will treat Vickie good and they will treat Emma Lou like dirt. That’s not right. We are all in the same situation.”*

*“Caseworkers tend to close us off so much, you know, because they are afraid to share resources. ...[they] have their own favorite resources that they share.”*

*“We all go to Social Services, why does one get more help than the other? That’s kind of hard.”*

### **Shelter Staff**

Every group that discussed shelter experiences shared negative interactions with program staff. The chief complaints were that staff treated them without respect, and/or that staff exhibited favoritism.

*“If you screw up, then you screw up, that’s on you. But you should be given the benefit of the doubt.”*

*“They treat you like you in jail. They treat you like you ain’t nobody. But...we humans just like they are.”*

*“We’re all adults here. So, if you can’t talk to me like I’m an adult then don’t talk to me at all. You have nothing at all to say to me if you can’t talk to me with the respect I’m giving you.”*

*“It’s safe to say that we get treated unfairly here, but there is nothing we can do about it. We live here and hey, what can we do?”*

A common perception of the participants was that staff withheld valuable information and meted it out based on favoritism, or they lacked knowledge of resources so that access to information was not equal.

*“They pick and choose who to help.”*

*“With you a whole lot of things are different. With other people the rules change. It depends here a lot of time on who you are whether the rule is enforced or not. And I think everybody is aware of that.”*

*“People don’t know the true resources so that they can help other people find what they need.”*

## **Health Care**

As with many of the services and resources discussed in this report, distrust and fear are the predominant reasons these women hesitated or failed to seek health care for themselves or their children.

*“I wouldn’t have taken her down there to that health clinic. I am not risking her life to take her down there and then who knows if the doctors are any good?”*

*“Why I didn’t want to come to the Health Care for the Homeless was because I don’t want my kids taken away from me. I don’t consider myself neglectful or ignorant or anything like that. I am not abusive. I am trying to keep my kids clean, I shower them, comb them, I constantly wash clothes in the sink for them because there are so many of them. I feel that if I get tangled in one little itty bitty stream of any kind with the homeless system, they’ll take my kids away.”*

*“Since we have been homeless I have paid more attention to the health care of my two children; it dawned on me, oh my gosh, he is so behind on immunizations ...so now I am trying to scramble to catch up before somebody realizes ...bad mother, bad mother, you know.”*

Another woman’s daughter had discolored teeth – the dentist she went to told her not to worry, but she scrubbed her daughter’s teeth intensively for fear someone would think poorly of her.

*“...these things were all there before, but I was an okay mother because I was at home, you know, I cooked, you know, but now that I don’t have a home to call home, I feel like people see little things like this...”*

Some women also expressed other reasons for not addressing their own health needs. For many, they simply did not have access to affordable care:

*“I have chronic health problems and I am on medications everyday and I have to be seen at the charity hospital and the free clinic. That’s the only way I can afford to get healthcare. My kids are covered, but I am not covered.”*

## **Job Skills/Training**

The majority of the women lacked the education and/or skills necessary for obtaining a livable-wage job, yet all were frustrated in their attempts to obtain useful job training. One woman described her frustration this way: *“It’s like credit. You don’t have credit, but you can’t get credit without having credit.”* She recommended that shelters or other programs provide specific job training and knowledge to assist the women. Certificate programs, such as the Certified Nurse’s Aide program, which pays trainees throughout the training process, are appealing, but not necessarily adequate because of the low wages that do not cover job-related expenses and living costs. Other women felt they needed assistance in writing resumes, completing applications, and finding access to useful skills training.

One woman felt helpless because she had a *“disability of learning”* which made it impossible to write an impressive application. In Arizona, the mothers mentioned how difficult it is to find a job if one is not bilingual.

*“I mean it is really very difficult to find a job if you don’t speak at least some Spanish. Bilingual people make a lot more money.”*

*“There are classes for you to learn how to speak English but there are not classes for free for you to learn to speak Spanish.”*

Only one woman in 100 had a positive experience with a job training program to share. The program was for computer training and a taxi picked the participant up, took the kids to day care, took her to work, picked her up from work, picked up the kids from daycare, and took everyone home every day. Programs that address women’s multiple needs and stresses as mothers, learners, and earners are most likely to provide women with the support and confidence they need, in part because they are designed so that they help reduce, rather than increase, stress.

### **Help for Domestic Violence Situations**

In general, these homeless mothers were aware of domestic violence or “battered women” shelters in their communities where they could go for help. They tended to seek such help when they were in crisis – a life and death situation. Interactions with advocates or counselors of any kind in domestic violence situations were rare. For many, fear contributed to their reluctance to seek help to escape their domestic violence experiences.

One woman who experienced abuse both as an adult and a child was able to ask for help only when her daughter watched her getting beaten:

*“Something just opened, and I was just like, a four year old has enough sense to know there’s something wrong about this. That’s not right, what the hell am I doing?”*

Trauma-sensitive and trauma-informed services are necessary for these mothers not only so that they are able to deal with their trauma experiences and avoid repeating them, but also because trauma experiences influence every other internal and external experience.

### **Parenting Supports**

The vast majority of these participants did not consider their own parents to be “ideal” role models; most had negative – often abusive childhood experiences. A key parenting issue, then, is the struggle these women experience in fighting against the only parenting role model they know. The following comments reflect this struggle and its implications for themselves and their children.

*“I was a child of incest, I had several cousins that were messing with me, okay? My biggest fear, trust me when I tell you this, was when I have a child will I do this to my child.”*

*“The way I was parented has everything to do with the way I parent because I tried so hard not to parent the way I was parented. ...I know how to bake cookies, but I don’t know how to be a nurturing mother, you know, that says, oh, my daughter wants to mix the batter, but she doesn’t do it the way I do it so it’s wrong. And it’s not wrong. You can mix chocolate chip cookie dough anyway you want to, you know, and it’s still going to make cookies. I am always fighting the way I was raised. ...If I need counseling for anything, that’s it.”*

Another talked about her struggle with keeping her children too close to her – being too protective of them and fearful for them, but at the same time wanting them to be trusting, friendly kids.

*“I am so scared of people in general, you know? ...That’s a cute dog and it might be harmless until it bites you and I don’t want my kids to be the ones that are bitten by these people that look like they are harmless and they are not. And they bring you into their little corner and win your trust and suddenly, you know, your whole life is flipped over again, you know, and I am so terrified of that, I keep them too tight.”*

In one of the groups, one of the mothers commented off-hand that “everyone” in the group had been abused and that’s why parenting was difficult. Participants confirmed that they each had experienced abuse as a child. Many of these mothers participated in parenting classes, either because of program requirements or because of their own initiative. Their experiences with the classes was mixed, but most found them at least somewhat useful.

*“..when I first came to the mandatory class, I didn’t want to be here, but after being here I thought ‘this is good for me.’”*

One mother said she had learned from parenting class that she should not rely so heavily on her teenagers: *“If anybody asks you to take a parenting class, take it. It helps.”* She herself had been given a lot of responsibility, paying bills and caring for her disabled sister when she was just 7 or 8 years old: *“I had to realize it is not their responsibility.”*

*“When you get through with that class you have a whole different respect about yourself, your children and ..how you handle your baby right.”*

Those mothers who were less positive about parenting classes expressed fears of being judged by counselors, fears that their methods would be considered abusive. One group of participants recommended a nonjudgmental safe place or a *“safety net of having other parents around”* to discuss parenting strategies in lieu of formal parenting classes.

## **Respite**

All mothers, especially single parents, need respite from their children in order to ensure their own well being. Many shelter programs discourage this by not providing respite opportunities and by insisting that mothers not share childcare responsibilities. The prohibition against sharing child care may be more so in traditional family shelters than in domestic violence shelters where there is often the recognition that women need “adult time”.

One mother commented that reprieve from her children would be of great help when she is overstressed and less likely to make a rational choice about how to discipline them: *“...they don’t offer any kind of stress relief. They don’t have a phone here so you can’t call the parent crisis line if you are going nuts and you just want to lay into your kids.”*

Many others also expressed this need for respite from their children. *“I don’t want to be stressed out with my child.”*

## **Other Support Services**

The women mentioned other support services that they thought would be helpful. One was legal aid for issues pertaining to their children – custody, support.

*“How come there are no lawyers for child custody? You have to pay for them. How come there’s no such thing as a free lawyer for child custody?”*

*“There’s DAs to help you when you go to court for drug addiction, when you go to court for...stealing cars, for this and that and you have a public defender right there, man, no problem, to help you. But when it has to do with the children you have no help. Society won’t help you.”*

## **Self Help Groups**

Nearly all of these mothers had discovered information about valuable services through word of mouth. Although they accessed services and information through formal means as well, their perception was that word of mouth was the most important overall means of access. In fact, in every focus group session someone brought up the idea that the participants should meet together “like this” more often to share resources and support – it was a positive experience for them.

In two groups participants came up with the idea during the discussion to compile a complete book of resources for new participants. They commented that the information-sharing happening in the focus group was very helpful and thought the information should be written down for others.

## **Summary**

As the focus group participants emphasize, social supports for poor and homeless mothers *are* unique. The support needs of these women differ significantly from those of middle class women described in the literature. Most important, homeless families’ basic needs are not being met, and they need instrumental support to meet these needs. The lack of housing, adequate food, health care, and decent-paying employment deprives them of a reasonable quality of life. Furthermore, because many women have also been victims of violence, their self-esteem is compromised and they may have difficulty pursuing, recognizing, and sustaining supportive relationships. Poverty, homelessness, and the perceived lack of concern for their plight on the part of society may intensify these feelings. Providing for basic needs and residential stabilization are the necessary initial steps in any service plan.

To receive social support one must have a reliable connection with sources of informal and formal support. Many homeless mothers lack consistent connections to informal supports as experience has taught them that other people are not trustworthy and they can only rely on themselves. Willingness to seek support is built on the perception and belief that support is available and will be helpful. Support is effective only when it is perceived as helpful and is freely sought. Many mothers have had negative experiences with both formal and informal supports, which account for their negative perceptions of supports and their reluctance to rely on others.

It may be difficult to appreciate how hard it is for a homeless mother to trust that services will be of any help and that they will be consistently available. The women in the focus groups repeatedly described services and providers as unresponsive to their needs and those of their children. Their perceptions of racism and favoritism within the service community fuels their distrust and anger and reinforces their sense that no one is really interested in helping them.

Thus, the service system that is supposed to help them is viewed by these women as merely another obstacle to recovery.

To be effective, any package of supports that aims to stabilize families must consider these points: basic needs must be met first; distrust and fear are nearly always part of a homeless woman's experience; and the way the service system currently functions often increases rather than reduces distrust, fear, and wariness about accepting services.



## Chapter Six: Best Practices

- **Overview**
- **Critical Supports for Homeless Families**
- **Supports Women Need When Entering Shelter**
- **Supports Women Need While In A Shelter**
- **Supports Women Need Once They Are Housed**
- **Summary**

### **Overview**

Support networks are vital for stabilizing homeless families and their children in the community and helping mothers transition to self-support. For all families, these supports are the foundation of social capital—a network of mutual or reciprocal social relationships to which mothers and families contribute, and from which they can draw resources over time.

In their role as single parents, many homeless mothers face severe stressors as they juggle their multiple roles of breadwinner, provider of emotional care, school advocate, teacher, manager, and “coach.” Women in our focus groups gave us valuable information about the type of supports they need and how best to deliver them, including:

- Providing instrumental support to meet basic needs.
- Understanding homeless mothers’ distrust and fear of providers, and the life experiences that contribute to these feelings.
- Willingness of providers to work patiently with mothers to help address these feelings.
- Adopting procedures and policies to increase mothers’ willingness to use available resources.
- Ensuring that supports are interdependent, rather than separate and isolated.

A “one-size-fits-all” package of supports will not address the needs of these women or their children. While acknowledging we are all interdependent and that homeless mothers require assistance to become self-supporting, service plans should be individualized and build on family strengths. Enhancing instrumental supports is an essential first step in assisting homeless families in their transition from homelessness.

Service plans must be generated in partnership with mothers. Short-range, measurable, achievable goals help to enhance a mother’s self-esteem and confidence. Since the passage out of homelessness is not a static event, supports need to be attuned to evolving needs as these women journey toward independence and residential stability. The supports described below correspond to changing needs as families move from homelessness to permanent housing.

### **Critical Supports for Homeless Families**

Based on a literature review, focus group discussions, and informal feedback from providers, all programs serving homeless families and children should provide a core group of support services central to stabilizing families and improving their well being. Critical services necessary for the overwhelming majority of mothers and children include:

**Housing assistance:** Most urgently, homeless mothers need decent, affordable housing. The National Alliance to End Homelessness (NAEH) emphasizes that re-housing options must be cost-efficient and “ensure long-term stability” (Toolkit for Ending Homelessness, 2003). To access these options, homeless mothers need assistance from providers who are knowledgeable about housing markets, have relationships with local landlords, can secure and convert housing rental vouchers, provide financial assistance to pay for housing fees, deposits etc., and understand the family’s needs.

**Income supports:** Families should be immediately connected to existing entitlement programs for which they are eligible. Additionally, transitioning from homelessness into permanent housing requires mothers to become self-supporting. During their shelter stay, mothers should begin to investigate education and job-training opportunities as well as enroll in programs to find jobs that pay livable wages.

**Transportation:** Transportation is necessary for mothers to meet shelter requirements, search for housing, and keep important appointments (e.g., health care, job interviews). Transportation is also vital if children are to attend school regularly.

**Childcare:** Most homeless mothers have at least two children, many of whom are less than five years old. To meet community service and work requirements, and to participate actively in housing and employment searches and other transition activities, their children need reliable, quality childcare. This can be provided either on site or through developmentally appropriate early intervention programs such as Head Start.

**Case management:** Homeless mothers and children have complex needs that involve multiple systems of care. These systems are often fragmented, uncoordinated, and difficult to negotiate. A case manager serves as advocate and service broker, providing the glue to hold the systems together. Since many homeless mothers are wary of these systems, case managers help them to access services. Case managers can also function as counselors who can be relied upon to help mothers through this difficult crisis. The relationship with the client can become a template for the mother for forming trusting, supportive, and sustaining interactions.

**Healthcare:** Homeless mothers and children have higher rates of acute and chronic medical illness. Many homeless mothers have not had the time or resources to obtain routine and preventive health care. All service programs must have a well-established referral network to primary health care providers for both mothers and their children.

**Trauma informed services with psychoeducational groups:** More than 90% of homeless mothers have experienced severe violent victimization as children or adults. For mothers fleeing abusive relationships, providers should help develop safety plans and obtain legal assistance. Because many mothers do not connect their current distress with their earlier experiences or understand the long-term effects of victimization, support groups are essential. Ten- to twelve-session support groups run by experienced facilitators can help mothers understand the dynamics of trauma, its impact on their emotional and physical health, the nature of their symptoms, the implications on parenting, and effective coping strategies. These groups are not used to recover memories or resolve personal issues related to trauma, but to focus on how trauma operates in their current lives. Since severe trauma has been reported as a risk factor for repeated episodes of homelessness, these groups play a critical role in helping mothers stabilize in housing.

**Children's services:** Children are often forgotten in the shelter world. Because resources are limited, it is often difficult for shelters to afford child development specialists on their staff. Even so, children must be thoroughly assessed and, whenever possible, referred to developmentally appropriate services. Older children may require support for their schooling as well as for after-school programs. For children with special needs, core assessments must be initiated. Case managers can help parents by advocating with the schools.

In addition to these essential supports for all homeless mothers, an array of other supports is vital for a subset of homeless women and their children. These include: mental health care,

substance abuse services, specialized trauma services, respite care, and specialized children's services. Such services may be more readily available through formal relationships with community agencies sensitive to the needs of homeless mothers and children.

## **Homelessness to Permanent Housing: Mobilizing Appropriate Supports**

### **Supports Women Need When Entering Shelter**

Losing a home has a devastating impact on all family members, including the children, as described in Chapters 4 & 5. Upon entering a shelter, the family's initial needs are for reassurance, establishing rapport with staff, and stabilization. Assigning a case manager to work with the mother and children can help immeasurably. The case manager's role is to become an anchor for the family. He or she works with the mother to form a trusting relationship, and functions as a resource coordinator and advocate.

To feel comfortable in a shelter setting, families need to be oriented to the physical layout of the shelter, and its routines and rules. Shelter orientation should include a tour of the common areas and a visit to the family's accommodations. Discussion of shelter rules and routines should be respectful, nonjudgmental, culturally sensitive, and trauma-informed. Equal application of shelter rules for all residents diminishes women's perceptions of favoritism on the part of staff. Whenever possible, mothers should be encouraged to continue with the usual routines and rituals they have with their children (e.g., when going to bed). Children rely on routines to ground their lives and to feel safe.

### **Supports Women Need While In A Shelter**

Once a family has been oriented and assigned a case manager, the case manager can begin the assessment process, which should be ongoing and flexible. When the case manager has gained an understanding of the family's needs and wishes, she or he can work collaboratively with the mother to develop immediate goals for the shelter stay. The children's needs should be assessed and addressed within a developmental context. Services and supports should be family-oriented and aimed concurrently at the family, the mothers, and the children.

The initial focus should be on addressing basic needs, such as housing, income supports, safety, and health care. A housing specialist should work with the mother to develop a realistic plan for obtaining stable housing. Mothers should have a voice in the location and type of housing that best meets their families' needs. Since families require income to pay for housing, utilities, food, clothing, and transportation, women may need assistance in obtaining income supports for which they qualify (e.g., TANF, unemployment, Social Security).

Many homeless families have experienced violence prior to their shelter entry. For these women, establishing a safety plan for their families is a top priority. Women who have left an abuser may need assistance and encouragement to secure legal assistance to deal with issues such as child custody and restraining orders. All shelter services should be trauma-informed. All staff should be aware of the pervasive role of trauma and victimization in the lives of homeless mothers and children, and shelter policies should be crafted to avoid retraumatization and support recovery. Shelter staff should be knowledgeable about the dynamics of trauma, the importance of establishing clear boundaries and rules, the invidious short and long-term effects of trauma on both women and children, and how to respond appropriately.

In addition to establishing a trauma-sensitive environment so that women are not triggered or retraumatized, services should foster healing. Since most homeless women have experienced severe trauma or violent victimization, shelters should provide psycho-educational support groups designed to raise mothers' awareness of the effect of trauma on them and their children, prompt improved understanding of how childhood experiences of victimization may

account for current distress, and provide concrete information on how to deal with their feelings (e.g., flashbacks, intrusive memories, emotional distress, triggers, etc.). Shelters that are unable to provide these services on-site should develop relationships with appropriate community agencies.

As part of the ongoing assessment, the case manager should try to determine whom the client views as supportive, in what ways, and the level of conflict. Relationships with siblings should be specifically explored since studies have shown that they are often sources of support for homeless women. The shelter stay can be used to try to explore and resolve some of the conflict and to strengthen these supports before the family leaves the shelter.

When families are in crisis, health care needs are often neglected. Immediate health needs of all family members should be addressed early in their shelter stay. If the family has no health insurance, the case manager should assist the mother in obtaining any health/dental coverage for which the family qualifies.

Shelter staff should be aware that family separation is a major stressor for many of these mothers and children. In some states, shelters do not admit teen-aged boys. Additionally, some children may have been placed in foster care prior to the shelter stay. Services should be accessed to support and reunify families, or help them maintain significant contact with family members living elsewhere (e.g., children in foster care, residential treatment, etc.).

Reliable and appropriate childcare is a prerequisite for mothers to pursue employment, education, or job training. Mothers may need assistance exploring and accessing available childcare options. Case managers can play a key role in ensuring that early intervention and childcare services are developmentally appropriate and of high quality. If these services are not available onsite, shelters should establish relationships with providers in the community who are prepared to address issues particular to homeless children.

Once children are settled in school or in childcare, women may need help locating job-training, education, and employment opportunities. Job-related supports for mothers might include: how to write a resume; the do's and don'ts of a job interview; how to dress for success; and where to access clothing appropriate for interviewing and working.

Shelters can support women in other critical ways. The women in our focus groups found the groups enormously beneficial—both as sources of information and as opportunities to talk with other women who had similar experiences. Informal support groups within the shelter setting should be encouraged. Shelter graduates can be invited back to share advice and experience with current guests.

Focus group participants also emphasized the importance of respite opportunities for the women and suggested they be built into every program. Respite care provides women with space and time to attend to their own business and enjoyment. A proscription against cooperative babysitting or the requirement that women supervise their own children at all times not only ignores the cultural practices of some groups in which all adults assume a parenting role, but also makes no allowance for a woman's need for time away from her children.

### **Supports Women Need Once They Are Housed**

Follow-up and after-care services can make an important difference in a family's success in maintaining housing and becoming connected to community supports. Because families are at heightened risk immediately after they are housed, access to after-care services provides stability as they adjust to and become established in their community. Service providers can help to identify and encourage linkage to community supports that help mothers create an interdependent network to meet the needs of women and children in the many dimensions of their lives—personal, emotional, financial, and parental.

Despite a reluctance to depend on others, women in our focus groups realized they “cannot make it alone.” They asked strongly for supports that move them toward independence and self-determination, rather than ongoing dependence. Various informal community supports can help anchor women and their families in a community. These include churches, parent support groups, playgroups for children, school/parent associations, and support groups for parents who have children with special needs. Connections with these supports help to form a network that meets the many needs of a single parent family.

### **Supports Women Need To Maintain Residential Stability**

As Camaso & Camaso (1986) point out, efforts to stabilize re-housed families require intervention to reduce their level of stress as well as increase the range and availability of support services. For families to remain stable in the community, significant efforts must be directed at the structural and systemic shortcomings that have made life so stressful for them in the first place. All those who work with homeless mothers and children need to be strong advocates on their behalf not only to provide direct services, but also to create fundamental policy change at local, state, and national levels. Attention needs to be directed at modifying macro level economic and social factors that threaten the stability of these families—such as poverty, unemployment or low-wage employment, crime, lack of affordable housing, inadequate attention to children’s special educational needs, and unaffordable health care.

### **Summary – Best Practices**

Helping relationships – both formal and informal – are the linchpin of any service plan designed to assist homeless mothers and their children reduce stress, increase supports, and attain residential stability. These relationships should be positive, non-judgmental, non-conflicted, and unconditionally accepting. It is crucial for providers and others to accept that women’s ability to form relationships is affected by their trauma and victimization experiences. These experiences can make it hard for women to trust, to feel safe in the world, and to be in relationships with strangers (providers).

The women in the focus groups talked about the alienation they feel from providers whom they perceive to display favoritism and racial preferences. We expected that the women would feel alienation from the formal service system, but the extent of their feelings of estrangement from providers was not expected. Providers should assume that the women they see will feel this disaffection. These feelings should be addressed calmly, openly, and frequently, if a helping relationship is to be successfully established.

The feelings of alienation and lack of trust are also an issue in the informal relationships/support networks of homeless mothers. To establish strong informal support networks these feelings should also be addressed in group settings where women can explore and learn about them. This can be done in support groups in shelters and in the community that focus on a variety of concrete as well as emotional issues.

The following are critical components of a helping relationship that can assist homeless mothers to stabilize in the community:

- The helping relationship is nonjudgmental, open, and accepting.
- Providers acknowledge that these women are parents and that motherhood is a key part of their identity.
- One primary provider functions as the coordinator of services for the entire family.
- Providers are sensitive to the woman’s feeling that favoritism is a major dynamic and that she feels less valuable than others. When appropriate, these feelings should be explored and resolved.

- The helping relationship is trauma informed and trauma sensitive. That is, it is built on an understanding of the effect of trauma and victimization on a woman's ability to form trusting relationships, along with understanding of the challenges of engaging these women in specialized services.
- Many women need a safe relationship where violence issues can be addressed. The provider must be able to recognize his/her own limitations in addressing this issue and be prepared to refer a woman to a community partner agency that can skillfully address the issue. Support networks consisting of a mix of informal and formal supports are vital for stabilizing homeless families in the community. While the helping relationship is key to engaging a woman in services and helping her begin to trust, there are additional key supports that women and families need, as discussed above. These include:
  - An informal support network that is safe, available, and truly sustaining.
  - Relationships with informal supports that are characterized by minimal conflict, since conflict can erode more positive interactions.
  - Access to affordable housing and appropriate entitlements.
  - Education, job training and jobs that are flexible and pay a livable wage.
  - Health care and transportation.
  - Case management with a primary provider.
  - Services that are trauma informed and trauma sensitive.
  - Integrated mental health and substance abuse services.
  - Psycho-educational groups and other specialized groups that address parenting, trauma, navigating the system, and life skills.
  - Comprehensive services to children, including outreach to the schools.
  - Childcare, respite care, and other parenting supports.

In summary, homeless mothers need a mix of informal and formal supports to access the resources they need to attain residential stability. They have experienced enormous stress in their lives with few resources to buffer the impact of that stress. Providers can effectively help these women and their families by establishing a helping relationship, facilitating the women's ability to grow a sustaining and sustainable informal support network, ensuring access to needed services, and advocating for the resources and services that homeless families need to permanently exit homelessness.

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